OUTPATIENT DIALYSIS SERVICES PAYMENT SYSTEM

*payment***basics**

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Individuals with end-stage renal disease (ESRD)—irreversible loss of kidney function—require either dialysis or kidney transplantation to survive. In 1972, the Social Security Act extended all Medicare Part A and Part B benefits to individuals with ESRD who are entitled to receive Social Security benefits. This entitlement is nearly universal, covering more than 90 percent of all people with ESRD in the United States.

Because of the scarcity of kidneys available for transplantation, most patients with ESRD (70 percent) receive maintenance dialysis. Medicare spending for outpatient dialysis and injectable drugs administered during dialysis was about $8.6 billion in 2008 and is a predominant share of revenues for dialysis facilities. Since 1983, Medicare has paid dialysis facilities a predetermined payment for each dialysis treatment they furnish. The prospective payment—called the composite rate—was intended to cover the bundle of services, tests, certain drugs, and supplies routinely required for dialysis treatment and is adjusted to account for differences in case mix and local input prices.

Technological advances have changed the provision of dialysis care since the composite rate was established. Consequently, the composite rate excluded several injectable drugs—such as erythropoietin, vitamin D, and iron—that have diffused widely into medical practice over the past decades. Providers are paid separately for these products, and in 2008, drugs comprised about 31 percent of facilities' Medicare payments. Beneficiaries pay a 20 percent copayment for both composite rate services and separately billable drugs.

To reduce incentives to overuse profitable separately billable drugs and improve provider efficiency, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) modernized the outpatient dialysis payment method by broadening the payment bundle and implementing a pay-for-performance program. Beginning in 2011, CMS will begin a four-year phase-in of the new outpatient dialysis prospective payment method. Facilities will be paid a single comprehensive rate that includes all ESRD-related services, including injectable drugs and selected laboratory services that were previously separately billable. Table 1 summarizes key differences between the old and new payment systems.

Defining the care that Medicare buys

Medicare covers two methods of dialysis—hemodialysis and peritoneal dialysis. In hemodialysis, a patient's blood is cycled through a dialysis machine, which filters out body waste. About 90 percent of all dialysis patients undergo hemodialysis three times per week in dialysis facilities. Peritoneal dialysis uses the lining of the peritoneal cavity to filter excess waste products, which are then drained from the abdomen. Patients undergo peritoneal dialysis five to seven times per week in their homes.

The unit of payment is a single dialysis treatment. Although different equipment, supplies, and labor are needed for hemodialysis and peritoneal dialysis, the payment system that begins in 2011 does not differentiate payment based on dialysis method for adults. However, the new payment method does differentiate payment based on dialysis method for children under age 18 years.

Under the new payment method, facilities are paid a single case-mix adjusted payment which includes composite rate services and ESRD-related drugs, laboratory services, and medical

This document does not reflect proposed legislation or regulatory actions.

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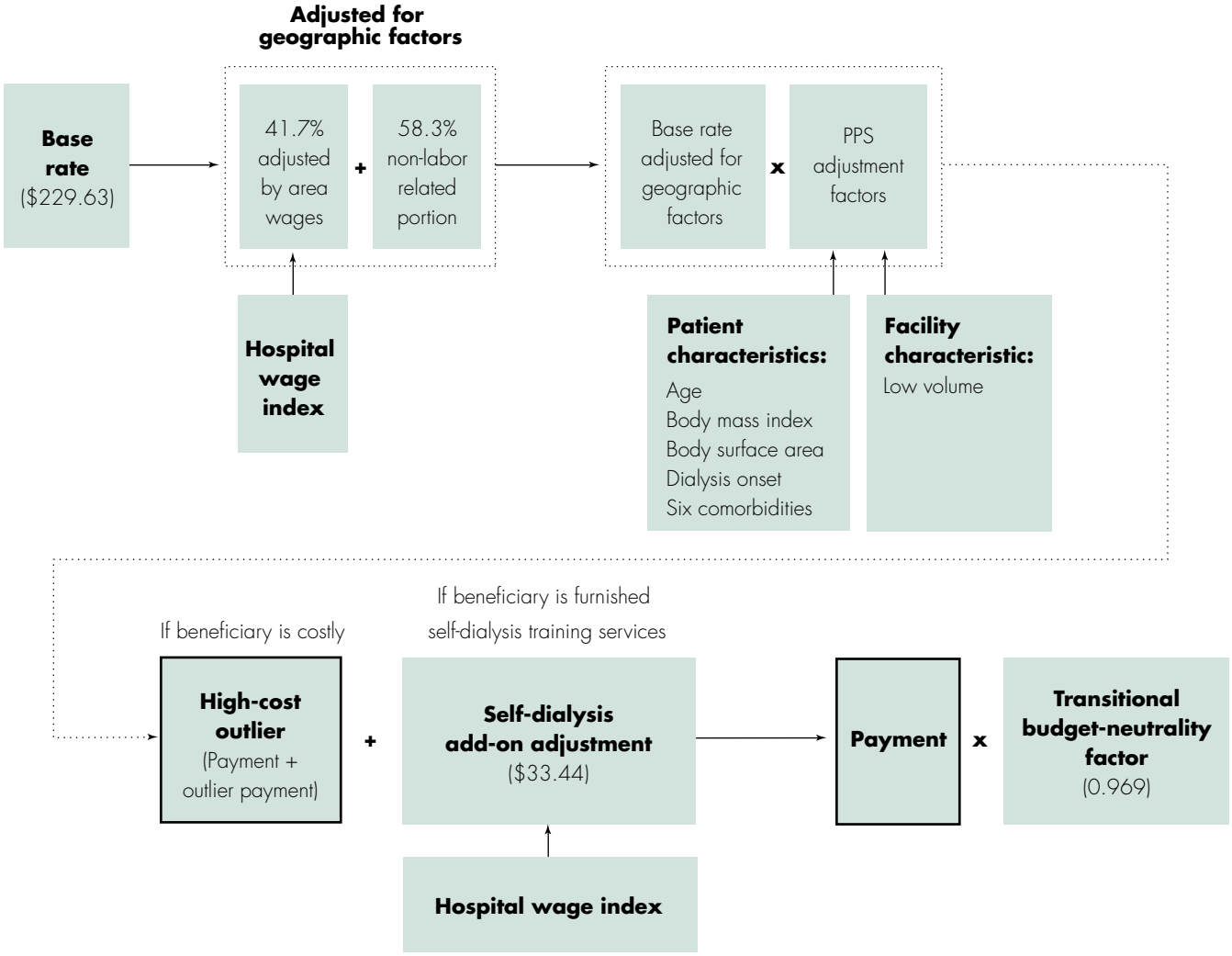
Figure 1 Dialysis prospective payment system in 2011



Note: This figure represents the payment method for beneficiaries 18 and older. For beneficiaries under 18: (1) the base rate, adjusted for geographic factors, is multiplied by patient case-mix characteristics (age and dialysis method); (2) the low-volume adjustment factor does not apply; and (3) the outlier payment policy, add-on for self-dialysis training services, and transitional budget-neutrality adjustment do apply.

equipment and supplies. The ESRD drugs included under the broader payment bundle include: (1) Part B ESRD-related drugs (including erythropoietin, injectable iron, and vitamin D analogs), and their oral equivalents; and (2) Part D oral ESRD-related drugs with no injectable equivalent (oral-only drugs that include calcimimetics and phosphate binders). However, until 2014, CMS will continue to pay for the oral-only ESRD-related drugs under Part D. This delay will enable the agency to complete an evaluation of the drugs' pricing data and address operational concerns about including oral-only drugs in the broader payment bundle.

Setting the base rate

The base payment under the broader bundle is intended to cover all operating

and capital costs that efficient providers would incur in furnishing dialysis treatment episodes in dialysis facilities or in patients' homes. For 2011, the base payment rate is $229.63 for freestanding facilities and for hospital-based facilities (Figure 1). Relative to the unadjusted average cost per treatment in 2011, the final base payment rate includes a 1 percent reduction to account for outlier payments and a 2 percent reduction to meet a statutorily required 98 percent budget-neutrality provision. Medicare pays for up to three dialysis sessions per week, although home dialysis may be given more frequently.

Patient-level adjustments—For adults, CMS adjusts the base rate for case mix using the following measures:

- age (18–44, 45–59, 60–69, 70–79, ≥80 years),
- two body measurement variables—body surface area and body mass index,
- six specific acute and chronic comorbidities, and
- onset of dialysis (for the first four months a patient receives dialysis).

For children under the age of 18 years, CMS adjusts the base rate by age and dialysis modality.

Facility-level adjustments—CMS includes two facility-level adjustments to the base rate. First, CMS adjusts the base rate for differences in local input prices by using the Office of Management and Budget's Core-Based Statistical Areas. The agency uses the acute care hospital wage and employment data for fiscal year 2007 to calculate the ESRD wage indexes in 2011. The labor-related portion of the composite rate is 41.7 percent for both freestanding and hospital-based facilities.

Second, CMS includes an 18.9 percent adjustment to account for the costs that low-volume facilities incur. A low-volume facility is defined as one that furnishes fewer than 4,000 treatments in each of the three years before the payment year and that has not opened, closed or received a new provider number due to a change in ownership during the three-year period. In addition, for new facilities that are Medicare-certified after 2011, CMS considers the facility's proximity to other commonly-owned facilities.

Outlier payments—Under the new system, CMS pays facilities an outlier payment when a beneficiary's payment per treatment for outlier services exceeds a threshold, which is the beneficiary's predicted payment amount per treatment for the outlier services plus a fixed dollar loss amount. Outlier services include drugs, laboratory services, and other items that facilities separately billed under the old payment method. The fixed dollar loss amount is $155.44 for adults and $195.02 for children. Medicare pays 80 percent of the facilities' costs above the threshold.

Self-dialysis training add-on payment

The new payment method includes a dialysis training add-on payment that is adjusted based on the same hospital wage index used to adjust the base payment rate. CMS pays up to 15 training treatments for peritoneal dialysis and 25 treatments for hemodialysis.

Budget neutrality provisions

In 2011, CMS applies two budget-neutrality factors to facilities' payments. The first factor is designed to ensure that overall program spending does not increase as a result of the provision that permits facilities to elect to be excluded from the four-year transition. This factor, in 2011, reduces facilities' payments by 3.1 percent.

The second budget-neutrality factor is mandated by a provision in the statute that requires that total payments in 2011 under the new payment method must be equal to 98 percent of the estimated total amount of payments for renal dialysis services that would have been made with regard to services in 2011 if the new system was not implemented.

Table 1 Key features of the old dialysis payment method and the new prospective payment method

Payment method feature	Old payment method	New payment method
Payment bundle	Composite rate services, which include: nursing, dietary counseling and other clinical services, dialysis equipment and supplies, social services, and certain laboratory tests and drugs	• Composite rate services • Separately billable (Part B) injectable dialysis drugs and their oral equivalents • ESRD-related laboratory tests • Selected ESRD Part D drugs • Self-dialysis training services
Unit of payment	Single dialysis treatment	Single dialysis treatment
Add-on payment to the composite rate	Yes	None
Self-dialysis training services adjustment	Yes	Yes
Beneficiary-level adjustments	• For adults: age, body surface, and body mass • For pediatric beneficiaries: none	• For adults: age, dialysis onset, body surface, body mass, 6 comorbidities • For pediatric patients: age, dialysis method
Facility-level adjustments	Wage index	• Wage index • Low-volume adjustment
Outlier policy	None	Applies to the portion of the broader payment bundle composed of the drugs and services that were previously separately billable
Quality incentive program	None	Begins in 2012

Note: ESRD (end-stage renal disease). The low-volume adjustment does not apply to pediatric patients.

Source: MedPAC analysis of CMS 2010 final ESRD rule.

Transitioning to the new payment method

The four-year transition to the new payment method begins in 2011. During the transition, ESRD facilities will be paid a blend of the new and old payment system. Alternatively, facilities may make a one-time election to move directly to the new payment method.

Payment updates

There is a mechanism in the law that annually updates payments to outpatient dialysis facilities. For 2011, the composite rate portion of the blended payment amount will be increased by the ESRD market basket, which measures the price increases of goods and services facilities buy to produce patient care.

Quality incentive payment program

The new payment also includes a quality incentive payment program. Quality measures will include anemia management and dialysis adequacy. Beginning in 2012, the bundled payment rate will be reduced by up to 2 percent for facilities that do not achieve or make progress toward specified quality measures. Facility-level scores will be publicly reported on-line and posted within dialysis facilities. ■